AAA MOW Intake Form

Meals On Wheels Intake Form

1. Personal Information: all information is required

1. Last Name

_____

2. First name

_____

3. AKA First name.

_____

4. Physical Street Address

_____

5. Physical City orTown

_____

6. Physical State

_____

7. Physical zip code.

_____

8. Is the client's mailing address the same as their residential address?

- ☐ A - Yes
- ☐ B - No

8a. Mailing street address

_____

9. Mailing city or town.

_____

10. Mailing state.

_____

11. Mailing ZIP code.

_____

12. Date of birth

_____/_____/_____

calculated age at assessment

13. Client's telephone number.

_____

14. What is the client's e-mail address?

15. Gender:

- [ ] A - Male
- [ ] B - Female
- [ ] C - Other

16. Reason for needing meals

- [ ] A - Hospital discharge
- [ ] B - NH/Rehab
- [ ] C - Unable to shop
- [ ] D - Unable to cook
- [ ] E - Homebound
- [ ] F - Needs help with meal
- [ ] G - Balance Issues/mobility issues
- [ ] H - Visual
- [ ] I - Other (describe in question notes)

16a. Other reasons for needing meals need

16b. Length of service for meals

- [ ] A - Short-term 0-6 weeks
- [ ] B - Long-term
- [ ] C - Unknown

17. Does the client have any of the following conditions/diagnoses?

- [ ] A - Dementia
- [ ] B - Depression
- [ ] C - Congestive heart failure
- [ ] D - COPD
- [ ] E - Hip/knee replacement
- [ ] F - Heart disease
- [ ] G - Hypertension
- [ ] H - Diabetes

18. Current living arrangement.

- [ ] A - Lives Alone
- [ ] B - Lives with others
- [ ] C - Unknown

19. Are you a U.S. veteran?

- [ ] A - Yes
- [ ] B - No

20. Household size, including the client

21. Estimated monthly income of the household

$

21a. Client's monthly income:

$

21b. Is the client's income level below the national poverty level?

- [ ] A - Yes
- [ ] B - No

Current year used for Federal Poverty Level

Poverty Income test current yr Client only

Poverty Income Test current yr household

Percent of poverty for client current year (if less than 100 client is in poverty)

Percent of Poverty for household Current year

22. Race (choose multiple)

- [ ] A - Non-Minority (White, non-Hispanic)
- [ ] B - White-Hispanic
- [ ] C - American Indian/Native Alaskan
- [ ] D - Asian
- [ ] E - Black/African American
- [ ] F - Hispanic
- [ ] G - Native Hawaiian/Other Pacific Islander
- [ ] H - Other
- [ ] I - Two or More Races
- [ ] J - Unknown

23. Ethnicity?

- [ ] A - Not Hispanic or Latino
- [ ] B - Hispanic or Latino
- [ ] C - Unknown

2. Emergency Contact Information

1. Emergency Contact Name:

2. Relationship of Emergency Contact

3. Day Phone of Emergency Contact

4. e-mail primary emergency contact?

5. Name of Emergency Contact 2?

6. Relationship to emergency contact 2

7. Phone of emergency contact #2?

8. e-mail of secondary emergency contact?

9. Primary care physician:

10. Primary care physician phone number:

3. Meal Information for meals delivery use

1. Meal Start date 1

_____/_____/_____

2. Meal End date 1

_____/_____/_____

3. Meal End reason 1

- ☐ A - Admitted to rehab or NH
- ☐ B - Admitted to the hospital
- ☐ C - Deceased
- ☐ D - Didn't like the food
- ☐ E - Got better
- ☐ F - Moved
- ☐ G - No longer need the meals
- ☐ H - On Hospice
- ☐ I - Other
- ☐ J - Other dietary needs

4. Meal delivery days

- ☐ A - Monday
- ☐ B - Tuesday
- ☐ C - Wednesday
- ☐ D - Thursday
- ☐ E - Friday
- ☐ F - Saturday
- ☐ G - Sunday

5a. Number Breakfast meals

5b. Number Bagged Suppers

5c. Number of frozen meals:

5d. Number of Other meals

6. Total meals per week

7. Meals Milk Type

- [ ] A - 1% milk
- [ ] B - 2% milk
- [ ] C - skim milk
- [ ] D - whole milk
- [ ] E - No Milk

8. Dietary information

- [ ] A - Regular
- [ ] B - Diabetic
- [ ] C - Vegetarian
- [ ] D - Gluten free
- [ ] E - Low acid
- [ ] F - Low fat/low cholestrol
- [ ] G - Low sodium
- [ ] H - Lactose Intolerance

9. Meal Texture

- [ ] A - Regular
- [ ] B - Ground
- [ ] C - Cut up
- [ ] D - Puree
- [ ] E - Soft
- [ ] F - Other

10. Describe the client's allergies, if any.

Comments regarding Home Delivered Meals. Include options for meal choices.

4. Delivery Information

1. Directions/Driver Notes:

2. Do you have pets

- ☐ A - Yes
- ☐ B - No
- ☐ Don't Know

3. Are pets controlled

- ☐ A - yes
- ☐ B - no

4. Does client drive a car

- ☐ A - yes
- ☐ B - no

5. Is client aware of referral:

- ☐ A - Yes
- ☐ B - No
- ☐ C - Client Not Cognizant

6. Name of person making Referral:

7. Date of Referral

_____/_____/_____

8. Special notes

5. Interviewer Check List

1. Meal Provider

2. information taken by:

3. Date of the intake

_____/_____/_____

4. Did you explain:

- ☐ A - Donation policy
- ☐ B - Pet Policy
- ☐ C - 24 hr notice/cancellation policy
- ☐ D - Home assessment (ILA) policy
- ☐ E - New Recipient package

6. Prioritization Questions

1. If you had groceries, would you be able to use them to prepare meals?

- ☐ A - Yes
- ☐ B - No

2. Do you have reliable help with meal preparation

- ☐ A - Yes
- ☐ B - No

3. Are you able to get groceries into your home when you need them.

- ☐ A - Yes
- ☐ B - No

4. In the last twelve months, we worried whether our food would run out before we got money to buy more

- ☐ A - Yes
- ☐ B - No

5. In the last twelve months, the food we bought didnt last and we didnt have money to buy more.

- ☐ A - Yes
- ☐ B - No

Below is the Nutrition Program Priority Score from 1 to 5 (A to E) , which is used to rank a waiting status in the MOW enrollment. 1 in the Nutrition Priority Food Insecurity indicates the person is food insecure.

Nutrition Priority A

Nutrition Priority B

Nutrition Priority B1

Nutrition Priority C

Nutrition Priority C1

Nutrition Priority D

Nutrition Priority D1

Nutrition Priority E

Nutrition Priority E1

Nutrition Priority Food Insecurity

Nutrition Priority Score

Title : _____ Date

Title : _____ Date